Department of Veterans Affairs **VHA HANDBOOK 1174.1**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **February 16, 2000**

BLIND REHABILITATION OUTPATIENT SPECIALIST PROGRAM PROCEDURES

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook is issued to provide procedures for all matters regarding the Blind Rehabilitation Outpatient Specialist (BROS) Program and to establish guidelines for these procedures.

2. SUMMARY OF CONTENTS: This Handbook describes the scope of the BROS Program and procedure guidelines for providing outpatient blind rehabilitation services in Department of Veterans Affairs (VA) medical facilities.

3. RELATED ISSUES: VHA Directive 1174 (to be published).

4. RESPONSIBLE OFFICE: The Office of Patient Care Services (11) is responsible for the contents of this Handbook. Questions may be referred to 202-273-8482.

5. RESCISSIONS: None.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of August 2004.

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BLIND REHABILITATION OUTPATIENT SPECIALIST PROGRAM PROCEDURES

1. PURPOSE

The purpose of this document is to provide guidelines and procedures for Department of Veterans Affairs (VA) management and blind rehabilitation personnel to follow regarding the Blind Rehabilitation Outpatient Specialist (BROS) Program.

2. BACKGROUND

a. VA has been committed to providing comprehensive rehabilitation services to America's blinded veterans since the late 1940's and has been an international leader in the rehabilitation of the blind. The model that was established at that time, a regionally based Blind Rehabilitation Center (BRC) designed to restore the twenty identified losses associated with the handicap of blindness, continues to provide the highest quality of care available. While VA has continued to expand its' inpatient programs in order to meet the "total rehabilitation" needs of blinded veterans, current "specific" demands being created by an aging veteran population have prompted Blind Rehabilitation Service to re-evaluate its service delivery system.

b. VA is currently experiencing a rise in the number of veterans being referred to the nine regional inpatient programs. A review of BRC statistics show that there were 1,945 applications for training in fiscal year (FY) 1998, which represents a 6.5 percent increase from FY 1996.

c. A study conducted by Gregory L. Goodrich, Ph.D., entitled Growth in a Shrinking Population: Visual Impairment in the Veteran Population 1995 – 2010, estimates that the incidence of blindness and severe visual impairment within the veteran population will dramatically increase during the years 1995 to 2010 due to age related causes. Visual Impairment Service Team (VIST) rosters are already reflecting this increase as annual narrative statistics for FY 1998 indicate that there are 33,528 blinded veterans nationwide compared to 29,383 in FY 1996. It is notable that 44 percent of the national VIST roster is comprised of veterans age 75 or older compared to 38 percent in FY 1996. Furthermore, 73 percent are over the age of 65 compared to 70 percent in FY 1996.

d. As veterans continue to age, it is not only expected that the number of blinded veterans will increase but that the number possessing multiple health factors that complicate their blind rehabilitation needs will also increase. In order to meet the special needs of this increasingly geriatric, blinded veteran population, Blind Rehabilitation Service has established a new service delivery model in the form of an outpatient rehabilitation training program. This Program serves as a major enhancement in rehabilitation for blinded veterans as it is designed to provide a community reintegration process through a continuum of care by:

(1) Conducting blind rehabilitation assessments of blinded veterans being considered for blind rehabilitation training.

(2) Providing pre-BRC and post-BRC training in the veteran's home environment and/or local VA facility.

(3) Providing local blind rehabilitation training to meet the limited needs of veterans who are not candidates for the comprehensive BRC Program.

e. Within this framework, the BROS Program is able to extend the services provided by a BRC to the blinded veteran's home environment resulting in a superior quality of rehabilitation. The BROS Program should be cost-effective by reducing the length of stay for veterans attending inpatient programs, and by obviating the need for inpatient training for those blinded veterans who have limited rehabilitation needs which may be met through training in their local environment. These program services should result in a shorter waiting time for veterans applying for participation in the inpatient program.

f. This newly created outpatient program is administered by a multi-skilled and experienced blind rehabilitation specialist (instructor). In order to prepare the specialist for this new responsibility, comprehensive cross-training in each blind rehabilitation discipline will be provided at one or more of the inpatient BRCs. It is expected that the instructor will have a basic working knowledge in all of the blind rehabilitation skill areas plus advanced technical knowledge and competencies in at least two of the following disciplines: orientation and mobility, living skills, visual skills, and manual skills. The instructor is known as a BROS and is expected to work independently while conducting assessments and training at the local VA facility to which the instructor is assigned or in the veteran's home environment.

g. BROS sites were initially selected based on a variety of factors, including: local management's willingness to support a new program; VIST activity at the local facility; and the rate of VIST Coordinator referrals to BRCs. Once these sites were identified, national recruitment commenced and a BROS was subsequently placed at each selected VA facility.

3. SCOPE

a. In the BROS model, blinded veterans are provided with rehabilitation services through local assessment and training which should either decrease the time needed to successfully complete an inpatient rehabilitation program, obviate the need for the inpatient program, or meet the needs of those veterans who are unable to participate in an inpatient residential rehabilitation program.

b. The scope of the BROS Program includes:

(1) **Assessment.** Assessment provides blind rehabilitation assessments on those veterans identified by the VIST as needing blind rehabilitation training.

(2) **Pre-BRC Training.** Pre-BRC training provides basic skill instruction that help address a veteran's immediate needs, including any safety issues. This training should help prepare the veteran for a positive and productive learning experience when the veteran attends the residential training program. Pre-BRC training may reduce the inpatient training time or result in obviating the need for admission to the inpatient program.

(3) **Post-BRC Training.** Post-BRC training provides advanced instruction and follow-up services to veterans discharged from a BRC Program. This helps ensure that expected results are being met and will allow for a smooth transition back to the community.

(4) **Local Training of Non-BRC Candidates.** Local training of non-BRC candidates provides limited training to veterans who are unable to participate in a BRC Program because of severe physical limitations, cognitive impairment, or other extenuating circumstances. Instruction assists the veteran in reaching a maximum level of independence in order to overcome the handicap of blindness. Assessment includes determining the veteran's need for adaptive aids related to the veteran's sight loss. Training includes teaching adaptive techniques and the proper usage of any recommended equipment.

(5) **Prosthetic Issuance.** Recommending adaptive devices based on justification of need and the ability of the blinded veteran to effectively utilize the device following training.

(6) **Case Management.** The VIST Coordinator is the case manager, who has overall responsibility for coordinating services for each eligible blinded veteran enrolled in the local VIST Program. The BROS is responsible for administering and coordinating specific blind rehabilitation training activities, both VA and non-VA, for veterans participating in the BROS Program.

(7) **Communication.** Maintaining open lines of communication with VIST Coordinators, BRC staff, and the VHA Headquarters management staff ensures program objectives are being met.

4. GOALS

The BROS Program goals are to:

a. Provide a continuum of care for blinded veterans that extends from their home environment to the local VA facility and the regionally based inpatient training program.

b. Provide high quality care in a timely, appropriate and cost-effective manner.

c. Provide a consumer based environment in which veterans will be empowered with the ability to incorporate newly acquired skills into their life activities.

d. Be a state-of-the-art model for outpatient blind rehabilitation services.

5. PROGRAM OBJECTIVES

The BROS Program objectives are to:

a. **Offer a Continuum of Care**. Offering a Continuum of Care means providing a rehabilitation model that allows a veteran to effectively transfer skills learned at the residential blind rehabilitation center and/or VA facility back to the veteran's home environment.

b. **Reduce Length of Stay at BRC**. The number of days required for successful completion of an inpatient blind rehabilitation program should be reduced by providing pre-BRC assessments and training as well as post-BRC training in the veteran's home area.

c. **Increase The Number of Veterans Served at BRC**. BRC Programs should be able to serve a greater number of blinded veterans due to a greater patient turnover rate resulting from the reduced length of stay for veterans assessed and trained by a BROS.

d. **Improve Timeliness of Intervention**. The waiting time experienced by veterans needing blind rehabilitation will be shortened by having a BROS conduct assessments and begin pre-BRC training in the local area.

e. **Address Specific Rehabilitation Needs of Non-BRC Candidates:** Veterans having physical or cognitive problems which preclude referral to a BRC, veterans unable to leave home due to other extenuating circumstances, and veterans who have been through a BRC program but need some additional training may have their limited needs met through BROS training. It is understood that a comprehensive blind rehabilitation program, as offered at a BRC, is not achievable on an outpatient basis.

6. BROS SERVICES AUTHORIZATION

a. **Blind Rehabilitation Assessment**. A BROS may conduct blind rehabilitation assessments on veterans identified by VIST as needing blind rehabilitation services. The assessment will include evaluations in Orientation and Mobility, Living Skills, Manual Skills, Visual Skills and (when indicated) Computer Access. The assessment forms will be mutually developed by the BROS and the BRC of jurisdiction based on nationally designed blind rehabilitation standards. During the evaluation, the BROS will assess each veteran's abilities and needs for blind rehabilitation training in addition to addressing the veteran's goals and readiness for any recommended training.

b. **Instruction and Training**. A BROS is authorized to provide instruction and training in all disciplines offered within blind rehabilitation to the extent to which they have been formally trained to provide such services. Instructors will use the latest teaching methodologies in blind rehabilitation supported with assistive training devices.

c. **Prosthetic Equipment**. A BROS is authorized to determine the blinded veteran's needs for blind aids and prosthetic equipment related to sight loss. A BROS may recommend, for initial issuance, adaptive equipment and sensory aids for which they are certifiable to provide instruction. ***NOTE:*** *For example, a mobility device, other than a cane issued for identification purposes, requires the BROS to possess a degree in Orientation & Mobility.* The initial issuance of an adaptive aid or appliance will follow the same guidelines used by Blind Rehabilitation Specialists at the BRC with which the BROS is affiliated. The initial issuance of an optical low vision aid requires written concurrence from a licensed eye care practitioner.

d. **Non-VA Services.** Generally all assessment and training will be provided by the BROS, but there may be situations when assessment and training beyond the BROS area of expertise is indicated. In such situations, the BROS should analyze and assess the quality of community blind rehabilitation services for possible referral arrangements. The BROS will determine the

appropriateness of referring to non-VA blind rehabilitation providers. Should contractual services be needed in lieu of a free community resource, contracts or agreements with qualified, professionally certified, blind rehabilitation professionals may be indicated. Contractual services should be recommended by the BROS with concurrence from the VIS Team and authorization from the local VA medical center. ***NOTE:*** *Contractual services should be closely supervised and monitored by the BROS.*

7. PRIORITY OF CARE

a. **Blinded Veterans Accepted for Admission to a BRC Program**. Veterans waiting for admission to an inpatient program are a high priority of the BROS Program. Within this group, veterans should be prioritized for BROS assessment and training based on patient safety issues, projected BRC admission date, vocational rehabilitation needs, distance from the BROS, potential impact on the length of stay, etc.

b. **Blinded Veterans Discharged to a BROS Program from a BRC Program.** Veterans needing post-discharge training to complete their BRC Program are a high priority. Within this group, veterans should be prioritized based on: projected discharge date, potential impact on the length of stay, home and/or community reintegration factors, vocational or volunteer pursuits, distance from the BROS, etc.

c. **Non-BRC Veterans.** Veterans not scheduled for participation in a BRC Program will be provided blind rehabilitation training as the BROS workload permits.

8. ORGANIZATION AND PROGRAM RESPONSIBILITY

a. **BROS.** The BROS is responsible for:

(1) Conducting blind rehabilitation assessments and providing blind rehabilitation training in the local community.

(2) Recommending prosthetic equipment for veterans participating in the BROS Program.

(3) Serving as an active member of the VIST.

(4) Serving as an extension of the BRC to which the VIST Coordinator refers veterans for comprehensive adjustment to blindness training.

b. **VIST Coordinator.** The VIST Coordinator is responsible for:

(1) The identification and screening of blinded veterans;

(2) Assisting eligible veterans in applying for blind rehabilitation training;

(3) Recommending prosthetic equipment for blinded veterans who are not participating in the BROS or BRC Programs;

(4) Coordinating non-blind rehabilitation training activities of cases currently active in the BROS Program;

(5) Conducting education and training programs on blindness for VA staff and the public; and

(6) Coordinating the activities of the VIST.

c. **BRC.** The BRC is responsible for:

(1) Providing comprehensive training in all aspects of blind rehabilitation at a VA inpatient facility;

(2) Reviewing and approving applications for training and maintaining a waiting list of accepted applications;

(3) Coordinating the admission date, treatment planning, and post-discharge training with the BROS in a timely manner;

(4) Ensuring that work accomplished by the BROS Program is not unnecessarily duplicated by the BRC in order to maximize the efficient delivery of services without compromising the quality of service delivery;

(5) Prescribing equipment for inpatients participating in the BRC program; and

(6) Providing cross-training and advanced training for the BROS.

d. **Blind Rehabilitation Service VHA Headquarters.** This office is responsible for:

(1) Establishing guidelines and program policy;

(2) Establishing and directing mechanisms for monitoring program effectiveness and identifying problem areas;

(3) Conducting site visits in order to educate local personnel concerning the Blind Rehabilitation Program and ensuring that adequate and appropriate services are being provided to blinded veterans at the local level; and

(4) Planning national education and training conferences.

e. **Prosthetic and Sensory Aids Service (P&SAS).** P&SAS maintains a stock of blind aids and dispenses equipment recommended by an appropriate healthcare professional and serves as an active member of the VIST. The VA facility housing the BRC furnishes adaptive devices recommended for all blinded veterans during inpatient rehabilitation, as well as those veterans who started training on a device at the BRC but completed their training under the tutelage of a BROS. ***NOTE:*** *For example, the BRC begins training a veteran on a closed circuit television (CCTV) but recommends that BROS complete the training at the veteran's home or work site.* The VA facility providing VIST services will assume responsibility for issuing any equipment exclusively recommended during outpatient training.

9. PROSTHETIC EQUIPMENT

a. **Basic Eligibility.** All blinded veterans with prosthetic eligibility needing aids and appliances used by the blind are eligible for assessment and training on such devices by a qualified healthcare professional. ***NOTE:*** *Eligibility is based on Public Law 104-262.*

b. **Criteria for Issuance.** Candidates must demonstrate the ability to utilize the equipment for the stated needs and/or goals as set forth by the BRC of jurisdiction. The guidelines for issuance will follow the same evaluation and training practices used by Blind Rehabilitation Specialists at the BRC of jurisdiction and will include written justification of need, training provided, and the capability of the veteran to utilize the equipment.

c. **Recommending Authority.** All clinically based blind rehabilitation personnel (BRC staff, BROS, and VIST Coordinators) have the authority to recommend prosthetic equipment for eligible blinded veterans.

(1) **BROS.** The BROS has responsibility for recommending the initial issuance of equipment (to the extent to which they have been formally trained to assess and provide such equipment) for veterans participating in the BROS program.

(2) **BRC.** When the veteran is admitted to the BRC Program, the BRC assumes responsibility for recommending prosthetic equipment until the veteran is discharged from the BRC.

(a) If post-BRC training is needed to meet the issuance criteria for any prosthetic device recommended by the BRC, the recommendation for issuance will require written concurrence from the BROS.

(b) If a new electronic prosthetic aid (e.g., CCTV, Optical Character Recognition (OCR), night vision device, etc.) is introduced by the BROS during post-BRC training, the recommendation for issuance will require written concurrence from the BRC.

(3) **Licensed Eye Care Practitioner.** The initial issuance of optical low-vision aids requires written concurrence from a licensed eye care practitioner and should adhere to the following procedure:

(a) The veteran is seen by an eye care specialist for ocular health examination.

(b) The eye care specialist recommends low vision training for near, intermediate and/or distant vision tasks. If the eye care specialist is knowledgeable in low vision, the recommendation may include a range of devices to be tested for various tasks.

(c) The BROS provides training and shares functional findings with the eye care specialist. ***NOTE:*** *The BROS assessment may include recommendations for specific sensory aid issuance.*

(d) The BROS and the eye care specialist concur on which sensory aids will best meet the veteran's needs. Concurrence will be in writing after which a recommendation for issuance will be sent to Prosthetics.

NOTE: *If an optical low-vision device is being recommended as a part of pre-BRC training, the BROS should consult with the BRC that the veteran will be attending for continuity of care.*

d. **Requests for The Purchase of Special or Experimental Aids, Devices, or Equipment in Excess of $1,000.00**

(1) Requests for the purchase of special or experimental aids, devices, or equipment in excess of $1,000.00, will require approval from either of the following, whichever is most appropriate for the local facility:

(a) VA medical center's Major Medical Committee.

(b) Visual Impairment Services Team.

(c) An ad hoc committee comprised of the BROS, VIST Coordinator, Chief of Prosthetics, and a designated licensed eye care practitioner.

(2) The request should include written justification describing why the veteran was unable to attend the BRC and may include a written recommendation from the BRC of jurisdiction to support issuance.

e. **VIST Coordinator**. For veterans not participating in a BROS or BRC Program, the VIST Coordinator has the responsibility for recommending the issuance of replacement prosthetic equipment. The VIST Coordinator may also recommend the initial issuance of basic aids and appliances, which are routinely used in activities of daily living and for which evaluation and/or training by a blind rehabilitation specialist may not be required. Basic items include but are not limited to: watches, clocks, timers; signature and writing guides; liquid level indicators, etc.

f. **Issuing Facility.** Devices recommended by the BRC during inpatient training will be issued by the Prosthetic Activity at the VA facility housing the BRC. ***NOTE:*** *This also applies to those veterans who started training on a device at the BRC, but completed their training under the tutelage of a BROS.* Prosthetic equipment initially recommended by the BROS during outpatient training will be issued by the local Prosthetic Activity at the VA facility providing VIST services.

g. **Loaner Equipment.** During outpatient training, the BROS may loan equipment for a temporary period of time as part of the training process to prepare a veteran for admission to a BRC program or for evaluation of functional ability.

h. **Pre-BRC Issued Equipment.** When prosthetic equipment is issued prior to a veteran's admission to a BRC program, the veteran should be encouraged to bring the equipment to the BRC, if appropriate, e.g., low-vision devices. The BROS and/or VIST should provide the BRC with a list of all pre-BRC issued equipment, e.g., copy of VA Form 10-2319, Record of Prosthetic Services.

NOTE: *Non-VA agencies or professionals involved with the veteran's rehabilitation plan may occasionally be asked to participate in the assessment, training, and prescription of services and/or devices.*

10. REFERRAL PROCEDURES

a. **BRC Referral.** The BRC referral process proceeds as follows:

(1) **Identification.** The VIST Coordinator identifies the blinded veteran and schedules a VIST Review. The VIST Review provides an evaluation that includes an eye examination, medical evaluation, hearing examination, benefit review, psychosocial interview, and patient education.

(2) **Documentation and Case Management.** As case manager, the VIST Coordinator completes a VIST assessment, which describes the veteran's functional capabilities and limitations. The assessment includes a patient history, current skill levels, needs, adjustment to blindness issues, veteran's goals, and a plan for treatment. BRC application procedures are completed by the VIST Coordinator for veterans needing or requesting comprehensive blind rehabilitation and sent to the regional BRC Program. A copy of the application packet is forwarded to the BROS.

(3) **BRC Application Review.** The BRC Program reviews the application and decides within 10 working days whether to accept or deny for admission. ***NOTE:*** *The BRC may request additional information before making a final determination.* Denials or requests for additional information are to be communicated directly to the VIST Coordinator, who then has 120 days to submit the needed information.

(4) **BRC Admissions Waiting List.** Applications that are accepted for admission will be added to the BRC Admissions Waiting List. Notification of such action is communicated by the BRC to both the VIST and the BROS. Applications that are pending receipt of additional information are placed on the waiting list. Veterans served by a BROS Program will only be given a BRC admission date after consultation with BROS. Any change in the admission date is communicated to the BROS.

(5) **BROS Opens Case.** The BROS opens new cases after a written referral has been received from the VIST Coordinator. The VIST Coordinator provides the BROS with a copy of the VIST assessment.

(6) **BROS Assessments**

(a) The BROS conducts a standardized assessment, which has been mutually developed with the BRC of jurisdiction, and is based on the nationally designed model. Administration of the standardized assessment is coordinated with the BRC and administered as close to the BRC admission date as possible. This assessment includes evaluations in Visual Skills, Orientation and Mobility, Living Skills, Manual Skills, and (when indicated) Computer Access in order to:

1. Identify goals and determine needs.

2. Evaluate the veteran's ability to learn and retain information.

3. Address the veteran's readiness for BRC training.

(b) A preliminary assessment may be conducted by the BROS immediately after receiving a referral from the VIST Coordinator in order to assess a veteran's suitability for training and determine the type of training to be provided (e.g., BRC or local). This assessment may be used to identify any safety issues and address the veteran's immediate needs. Such an assessment is to be included in the BRC application packet assembled by the VIST Coordinator. ***NOTE:*** *See BROS Preferred Practice Patterns for clinical process.*

(7) **BROS Individualized Treatment Plan.** The BROS develops an individualized treatment plan for each veteran with blind rehabilitation potential. The treatment plan will include veteran and/or family goals, as well as achievable and measurable outcomes. The BROS consults with the VIST Coordinator regarding training needs identified in the VIST referral. The treatment plan consists of findings from the assessments and recommends a course of action that maximizes VA resources to best meet the needs and capabilities of the blinded veteran. When indicated, the treatment plan includes the reasons for obviating admission to the inpatient program. For those veterans who will be attending the BRC for comprehensive training, the treatment plan requires concurrence from the BRC. Recommendations for pre-BRC training and a description of any post-BRC training that can be provided is to be included in the plan.

(8) **Obviating the Need for Admission.** Veterans who have their training needs met locally but would have attended a BRC if a BROS was not available to provide assessment and training, are considered obviated cases. An obviation is based upon veteran input and clinical observation by the BROS during the assessment and training process. The BROS consults with the VIST Coordinator regarding these findings. BRC management must concur that the veteran's needs should be met via local training. The case will be considered formally obviated when the BROS provides the BRC program and the VIST Coordinator a final summary of treatment. ***NOTE:*** *See BROS Preferred Practice Patterns for clinical process.*

(9) **Pre-BRC Training.** The BROS conducts appropriate pre-BRC training in consultation with the BRC management team and documents services provided. This training is targeted to address a veteran's urgent needs and to reduce the length of stay in the BRC program. Instruction should concentrate on basic skills. If safety issues arise that require advanced training, the BROS should contact the BRC to arrange a priority admission. The BROS will provide the BRC with up-to-date assessment and training reports prior to the veteran's admission. ***NOTE:*** *See BROS Preferred Practice patterns for clinical process.*

(10) **Admission to BRC.** In consultation with the BROS, a mutually agreeable admission date is established by the BRC program. The date should maximize the potential impact of the BROS Program to shorten the length of stay and still meet the needs of the blinded veteran. Pre-BRC training should be completed within 10 working days of admission. Training information is submitted to the BRC at least 1 working day before the veteran's admission date.

(11) **BRC Training.** The BRC creates an individualized training program that addresses the veteran's specific situation by using veteran input plus BROS assessments and recommendations. Should BRC staff members feel a need to repeat any assessments or training previously completed by the BROS, they must first consult the BROS.

(12) **BRC Patient Staffing.** A patient staffing will be conducted in order to review the initial treatment plan, discuss any goal changes, and begin discharge planning. Both the referring VIST Coordinator and the BROS need to participate in the patient staffing.

(13) **BRC Discharge Planning.** Prior to the discharge date, the BRC treatment team coordinates the discharge date and any necessary follow-up training with the BROS.

(14) **Post-BRC Training and Follow-up.** The BROS is to be involved in the veteran's discharge planning to ensure that post-BRC training can effectively address recommendations for follow-up and can commence within 10 days of discharge from the BRC. BRC final summaries are to include recommendations for follow-up that take into consideration the BROS areas of expertise. Summaries will be sent to the BROS no later than 3-working days after discharge. The BROS will then provide post-BRC discharge follow-up and transitional training in the veteran's home area or most appropriate environment. It is anticipated that post-BRC training will normally be completed within 30 days of discharge from the BRC. ***NOTE:*** *See BROS Preferred Practice Patterns for clinical process.*

(15) **BROS Closes Case.** Based upon clinical observation and veteran input, a determination is made by the BROS that the veteran has reached maximum potential. The BROS notifies the veteran of this finding and closes the case after writing a final summary. The final summary describes the treatment provided and includes the number of assessment and training hours devoted to pre-BRC and post-BRC blind rehabilitation. The final summary is entered into the veteran's medical record and a copy is sent to the BRC and the VIST Coordinator. ***NOTE:*** *This also applies to obviated cases.* If a veteran desires additional blind rehabilitation in the future, contact must be established with the VIST Coordinator to repeat the assessment and training process.

b. **Local Training Referral.** The process for referral to local training is as follows:

(1) **Identification.** The VIST Coordinator identifies the blinded veteran and provides an evaluation that includes an eye examination, medical evaluation, psychosocial interview and patient education.

(2) **Documentation and Case Management.** As case manager, the VIST Coordinator completes a VIST assessment, which describes the veteran's functional capabilities and limitations. The assessment includes a patient history, current skill levels, needs, adjustment to blindness issues, veteran's goals, and a plan for treatment. Veteran's who are not considered candidates for the comprehensive BRC Program, but who have limited blind rehabilitation needs, may be referred by the VIST Coordinator to the BROS for local training.

(3) **BROS Opens Case.** The BROS opens a new case after a referral has been received from the VIST Coordinator. The VIST Coordinator provides the BROS with a copy of the VIST assessment.

(4) **BROS Assessment.** The BROS assesses the veteran's capabilities and needs. A copy of the completed assessment is shared with the VIST Coordinator. The BROS determines the type of training to be provided based upon the BROS assessment along with input from the veteran and VIST Coordinator (and Licensed Eye Care Practitioner if optical aids are included as part of the training).

(5) **BROS Individualized Treatment Plan.** The BROS instructor develops an individualized treatment plan for each veteran with blind rehabilitation potential. The treatment plan will embody the veteran's input. The BROS consults with the VIST Coordinator regarding training needs identified in the VIST referral. The treatment plan will report findings from the assessments and recommend a course of action that maximizes VA resources to best meet the needs and capabilities of the blinded veteran. Each individualized training plan includes veteran and/or family goals, as well as achievable and measurable outcomes. Included in the plan is a description of the BROS training to be provided along with recommendations for any non-VA training.

(6) **Rehabilitation Training.** The BROS provides instruction and training in their areas of expertise. The BROS will analyze and assess the quality of community blind rehabilitation services for possible referral arrangements in skill areas outside of their expertise. The BROS will identify and assess veterans for the appropriateness of referring to non-VA blind rehabilitation providers; monitor the treatment process; and participate in revisions of the treatment plan and goals as determined by the performance of the veteran.

(7) **BROS Closes Case.** Based upon clinical observation and veteran input, a determination is made by the BROS that the veteran has reached maximum potential. The BROS notifies the veteran of this finding and closes the case after writing a final summary. The final summary is entered into the veteran's medical record and a copy is sent to the VIST Coordinator. If a veteran desires additional blind rehabilitation in the future, contact must be established with the VIST Coordinator to repeat the assessment and training process.

11. ASSESSMENT AND TRAINING SCHEDULE

The BROS is responsible for establishing a daily work schedule that best meets the needs of the blinded veterans on their active caseload as well as the BRC with which they work. Since BROS assessments and training take place in a variety of environments, the schedule needs to demonstrate an effective utilization of time while accounting for adequate travel time needed to reach various home locations. It is anticipated that the daily schedule will vary from one day to the next in order to have the greatest possible impact on meeting the needs of as many veterans as possible.

12. WORK ENVIRONMENT, EQUIPMENT, AND SUPPLIES

a. The work environment for the BROS encompasses a wide range of areas, including:

(1) VA facilities,

(2) Employment sites,

(3) School campuses,

(4) Residential areas,

(5) Downtown and urban environments,

(6) Rural areas,

(7) Shopping centers, and

(8) Indoor malls.

b. In order to provide services in a cost-effective manner, each BROS needs adequate office and clinical space within the VA facility to conduct assessments and provide training to blinded veterans. The assigned space should be located in an area of the VA facility that is convenient to the blinded veteran. Facilities are responsible for providing appropriate office space to enable the BROS to perform their assigned duties. ***NOTE:*** *It is recommended that a minimum of 300 square feet of office space be provided.*

c. Since one of the primary objectives of the BROS Program is to provide a smooth transition into the home area, the BROS will need ongoing access to a government vehicle. This vehicle will be used to travel to and from the veteran's home environment as well as other areas within the community.

d. BROS programs are to be provided with start-up funding to purchase training equipment, office equipment, and supplies. Funding for the purpose of replenishing supplies, leasing a government vehicle, and arranging for local non-VA contract services (if necessary and available) is determined by local facility management. Each BROS must develop and submit an annual operating budget, which displays a cost-effective use of departmental resources. ***NOTE:*** *The BROS should be provided with patient care funds if extended training of veterans away from the facility is indicated.*

13. DOCUMENTATION AND WORKLOAD REPORTING

a. The documentation of patient assessment and treatment is accomplished according to VHA Blind Rehabilitation and local VA facility policy. Documentation of workload, client demographics, costs, and other administrative activities required by the local VA facility are to be recorded.

b. A semi-annual workload report will be generated by each BROS at the end of the second and fourth quarter of each fiscal year (March 31 and September 30). This report will be transmitted to the Blind Rehabilitation Service at VHA Headquarters, with a copy forwarded to the BRC of jurisdiction.

14. PROFESSIONAL TRAINING

a. A key component of the BROS Program is the placement of multi-skilled blind rehabilitation specialists at local VA facilities. These instructors should be knowledgeable in all components of the inpatient Blind Rehabilitation Program (Orientation and Mobility, Living Skills, Visual Skills, Manual Skills, and Computer Access Training) in order to properly conduct assessments, provide local training, and have the greatest impact on reducing the length of stay in the BRC program.

b. Each BROS needs to have advanced technical knowledge and competencies at the journeyman level in at least two of the following skill areas: Orientation and Mobility; Living Skills; Visual Skills; and Manual Skills. In order to develop these competencies, a national cross-training curriculum is being developed to serve as a guideline for meeting the training needs of a BROS based upon the BROS's educational background and professional experience in the field of blind rehabilitation. Personnel new to the BROS Program need to complete this course of study prior to beginning their BROS assignment in order to enhance their skills, develop a trusting relationship with their assigned BRC, and gain a better understanding of VHA and its' Blind Rehabilitation Program. The cross-training curriculum includes:

(1) Training at the regional BRC Program that serves the VA facility where the BROS program is located.

(2) Assessment and skill area instruction in disciplines for which the BROS instructor is not already proficient.

(3) Training on the organizational structure, policy and procedure of the VA and local field facilities.

(4) Activities that encourage teamwork and facilitate communication between the BROS instructor and BRC staff.

(5) A mini-residency program (3 to 5 days) at an active BROS Program.

(6) An orientation to the duties and responsibilities of the VIST Coordinator.

c. Blind Rehabilitation Service, VHA Headquarters, will conduct periodic education and training programs designed to keep the BROS up-to-date on the latest developments in the field. A BROS is expected to keep abreast of new information, techniques, and any treatment or equipment that might impact the program. ***NOTE:*** *Reading professional journals and attending professional conferences or workshops are some methods that can be used to accomplish this requirement.*

d. A BROS should participate in periodic intra-VA details to the regional BRC. These training experiences provide opportunities for participants to:

(1) Develop and enhance clinical skills;

(2) Acquire updated technological information;

(3) Understand new curriculum approaches and teaching techniques;

(4) Coordinate procedures through a blind rehabilitation continuum of care model;

(5) Network with new BRC staff; and

(6) Improve the quality of consumer services.

NOTE: *When indicated, VIST Coordinators should be included in the educational program.*

DEFINITIONS

1. Activities of Daily Living (ADL). The instructional area that addresses the daily tasks that are necessary to get along in life. It encompasses a broad range of activities including personal hygiene, preparing a meal, managing household chores, etc.

2. Assessment (Preliminary). An assessment conducted prior to the Visual Impairment Services Team (VIST) Coordinator making a referral to a Blind Rehabilitation Center (BRC). It is used to determine any immediate needs and address any safety issues. It begins the process of evaluating the veteran's ability to learn and retain information in addition to identifying goals.

3. Assessment (Standard). An assessment, which has been mutually developed by the Blind Rehabilitation Outpatient Specialist (BROS) and the BRC of jurisdiction based on the nationally designed model. It includes evaluations in Orientation and Mobility, Living Skills, Manual Skills, Visual Skills, and (when indicated) Computer Access. The assessments are used to determine the veteran's current skill level relating to safety and efficiency in performing tasks while also addressing the veteran's readiness for BRC training. ***NOTE:*** *These assessments should be coordinated with the BRC and administered as close to the projected BRC admission date as possible.*

4. Assistive Technology. Devices used to improve an individual's functional capabilities (e.g., speech and communication technology, travel aids, low vision aids, hearing aids, etc.).

5. Blind Rehabilitation Center (BRC). A residential inpatient program that provides comprehensive adjustment to blindness training and serves as a resource to a catchment area usually comprised of multiple Veterans Integrated Service Networks (VISN's).

6. Blind Rehabilitation Outpatient Specialist (BROS). A multi-skilled and experienced blind rehabilitation instructor who has advanced technical knowledge and competencies in at least two of the following disciplines at the journeyman level: orientation and mobility; living skills; manual skills; and visual skills. The BROS has been cross-trained to acquire broadly based knowledge in each of these BRC disciplines plus computer access training.

7. Blind Rehabilitation Specialist (Instructor). The Department of Veterans Affairs (VA) position title that refers to the BROS as well as the BRC staff who assess, plan, and instruct in one of the BRC disciplines. It designates an instructor with a Bachelor's Degree (or higher) in one or more of the specialized areas of working with the blind; or a professional, who possesses a Bachelor's Degree (or higher) in an allied health profession who has an expertise in one or more of the specialized areas of working with the blind.

8. Blind Rehabilitation Specialist (Services). The VA position title, which designates a VIST Coordinator.

9. Communication Skills. The instructional area that teaches the use of adaptive skills and assistive technology for accomplishing tasks such as reading, writing, typing, financial management, storing and retrieving information, etc.

10. Community Integration. Adjustment activities that help a person gain the attitudes and skills needed to restore involvement in the family and community. This includes, but is not limited to, participation in social and recreational activities in the community, physical exercise, hobbies, integration into work and school settings, social adequacy within the family, etc.

11. Computer Access Training. The instructional area that teaches the skills necessary to use specialized display equipment in order to operate computers. This includes evaluating the ability of the person served to use large print, synthetic speech, and/or braille access devices in order to perform word processing functions and other computer related activities.

12. Continuum of Care. Refers to blind rehabilitation training that extends across the veteran's home environment, local VA facility, and regionally based inpatient training program.

13. Cross-Training. Training that extends beyond one's formal training and is intended to maximize the instructor's area of expertise by combining specific instruction from other closely related disciplines. The training is provided by instructors with verifiable competencies in the BRC program disciplines of Living Skills, Orientation and Mobility, Manual Skills, Visual Skills, and Computer Access.

14. Health Care Professional. For this handbook, the term "health care professional," refers to a licensed eye care practitioner, physician, or Blind Rehabilitation Specialist (Instructor).

15. Instruction (Basic). Introductory training that addresses skills utilized by visually impaired individuals in order to manage everyday life tasks. These may include, but are not limited to: pre-cane skills such as sighted guide and independent protective techniques; self-care techniques such as eating skills and personal grooming; health management such as labeling medicines; ADL's such as telling time, dialing a telephone and identifying money; using talking books; etc.

16. Instruction (Advanced). Skill training that takes place by a sequencing of lessons which are designed to integrate and expand upon techniques taught during basic skill instruction in order to perform more complex tasks. Examples include, but are not limited to: business area travel, such as crossing streets with traffic lights and using public transportation; communication skills, such as typing and using reading machines; adaptive kitchen skills, such as hot meal preparation; computer access training, etc.

17. Legal Blindness. Legal blindness exists when a person's best corrected central visual acuity in the better eye is less than or equal to 20/200, or if the central visual acuity in that eye is better than 20/200, but the visual field dimension is less than or equal to 20 degrees at the widest diameter.

18. Major Medical Equipment Committee. A committee comprised of medical, allied health, therapy, and engineering personnel who are knowledgeable about prosthetic equipment and rehabilitation. It is responsible for reviewing requests for major prosthetic equipment which cost over $1,000, or items of questionable need, prescribed by staff or fee-basis physicians to ensure that the requested items are necessary for the treatment and/or rehabilitation of the veteran.

19. Manual Skills. The instructional area that is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing,

problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

20. Obviation. Designates a procedure whereby a veteran is referred to a BRC program by the VIST Coordinator and placed on the BRC waiting list. The BROS proceeds to complete the standard BRC assessments during which time the person being served is noted to demonstrate physical and/or cognitive contraindications for participation in the comprehensive BRC program or the veteran is noted to have limited needs which may be met via local training. The BROS subsequently provides local training in consultation with the BRC that satisfies the veteran's needs. As such, obviated cases refer to veterans who would have attended the BRC had a BROS not been available to provide assessment and training. A veteran is considered to be a regular "local training" case for reporting purposes when the VIST Coordinator states in the treatment plan that the veteran is not regarded as a BRC candidate, but has limited blind rehabilitation needs that could be met on an outpatient basis.

21. Ocular Health Examination. An examination conducted by a licensed eye care practitioner that identifies the level of, and reasons for, a person's visual impairment. The examination includes a refraction to establish best corrected central visual acuities (not using eccentric viewing). It includes a thorough assessment of the visual system and ocular health to establish the diagnosis primarily responsible for the impairment and to ensure that all ocular and visual disorders are being appropriately managed. The examination provides the licensed eye care practitioner with information essential to conducting and/or directing additional assessments and management strategies centered on the delivery of optimal visual impairment rehabilitative services.

22. Optical Low-Vision Device. Any device that alters the image focus, size (magnification), contrast, brightness, color, or directionality of an object through the use of lenses or other technology. Such devices include, but are not limited to: eyeglasses (with or without tint), microscopic spectacles, hand held magnifiers, stand magnifiers, telescopes (monocular or binocular), headborne lenses, minifiers, prisms, and closed circuit televisions (CCTV).

23. Orientation and Mobility (O&M). The instructional area that addresses the use of the remaining senses in combination with skill training utilizing protective techniques and assistive devices in order to independently travel in a safe, efficient, and confident manner in both familiar and unfamiliar environments.

24. Preferred Practice Patterns. Statements developed as a guideline for blind rehabilitation specialists which specify procedures, clinical indications for performing the procedure, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes.

25. Prosthetic Activity. Includes any Prosthetic Treatment Center, Prosthetic and Sensory Aid Service, (PSAS), or section established in a VA facility that is charged with the responsibility for the Prosthetic Program at that facility.

26. Prosthetics. A broad term used to identify the total concept of the fields of prosthetics, orthotics, sensory aids, aids for the blind, medical equipment, medical supplies, components, and repairs.

27. Sensory Aids. Items and devices which are designed to compensate for deficiencies in sense organs (e.g., low vision aids, hearing aids, speech and communication aids, long cane, etc.).

28. Special and/or Experimental Appliances. Includes any orthopedic, therapeutic or rehabilitative device, or item of medical equipment costing in excess of $1,000 which is not covered by VA contract or available from VA supply depots. It refers to newly developed or unusual items which, regardless of cost, have not been previously issued by the health care facility and which may require BRC review, clinical evaluation, or testing.

29. Veteran's Health Administration (VHA). One of three agencies comprising the Department of Veterans Affairs that has as its' primary mission the provision of healthcare to America's veterans.

30. Visual Impairment Services Team (VIST). A team comprised of health care and allied health care professionals charged with the responsibility for determining the comprehensive services required by a visually impaired veteran. Representatives may include, but are not limited to: ophthalmology, optometry, medicine, audiology and speech pathology, prosthetics, social work, nursing, administration, vocational rehabilitation, adjudication and veterans benefits. ***NOTE:*** *The VIST may include a representative from the local Blinded Veterans Association as well as a representative from a local agency for the blind.*

31. Visual Impairment Services Team (VIST) Coordinator. The VIST Coordinator is a case manager who has major responsibility for the coordination of all services for visually impaired veterans and their families. Duties include providing and/or arranging for the provision of appropriate treatment modalities (e.g., referrals to BRCs and/or BROS) in order to enhance a blinded veteran's functioning level. Other duties include identifying new cases of blindness, providing professional counseling, resolving problems, meeting specific objectives established by the VIST, arranging VIST Reviews, and conducting educational programs relating to VIST and blindness.

32. VIST Review. A formal process that includes a physical examination, eye exam, and VIST Coordinator interview during which needs of the veteran are identified and the veteran is advised of the full range of services and/or benefits for which the veteran is eligible. The VIST assessment includes patient history, current skill levels, adjustment to blindness and current needs. It results in a description of the veteran's functional capabilities and limitations. This results in the formulation of a treatment plan which includes recommendations for other needed exams, services, and follow-up as indicated.

33. Visual Skills. The instructional area that addresses the needs of persons with partial vision, to gain a better understanding of their eye problems through patient education, and teaches them how to effectively utilize their remaining vision through the use of low-vision techniques. It includes assessment and training with special optical aids and devices designed to meet the various needs of the person served. These needs may include reading, activities of daily living, orientation and mobility, home repairs, etc.

SAMPLE FORMAT FOR THE BLIND REHABILITATION OUTPATIENT SPECIALIST (BROS) SEMI-ANNUAL REPORT

BROS Semi-Annual Report

[VA Facility]
[Reporting Dates]

1. CASELOAD

a. Total number of veterans served.
b. Cases opened (i.e., started).
c. Veterans obviated the need for a Blind Rehabilitation Center (BRC) Program.
d. Veterans admitted to a BRC Program.
e. Veterans discharged from a BRC Program.
f. Pre-BRC training.
g. Post-BRC training
h. Non-BRC (i.e., local) Training.
i. Cases completed (i.e., closed).

2. HOURS OF EVALUATION AND INSTRUCTION IN EACH SKILL AREA

	Pre-BRC Assessment and training	Post-BRC	Local Assessment and training
a. Orientation and Mobility.			
b. Living Skills.			
c. Low Vision.			
d. Manual Skills.			
e. Computer and/or Electronic Reader Skills.			
f. Community Integration.			

3. BROS ENCOUNTERS

	Number of Pre-BRC	**Number of Post-BRC**	**Number of Local**
a. Home Area.			
b. VA Facility.			
c. Phone.			

4. TIMELINESS

a. Average Wait in Days for Pre-BRC Services. _____
b. Average Length of Stay in Days at a BRC Program. _____
c. Average Wait in Days for BROS Follow-up Services. _____

5. DEMOGRAPHIC DATA

a. **Pathology** **Number of Veterans**

(1) **Cataract**
(2) **Choroid Retinal**
(3) **Diabetic Retinopathy**
(4) **Glaucoma**
(5) **Macular Disease**
(6) **Retinal Detachment**
(7) **Optic Atrophy**
(8) **Optic Nerve**
(9) **Trauma**
(10) **Other**

b. **Major Activity**

(1) **Employed for Pay**
(2) **School**
(3) **Volunteer Work**
(4) **Retired**
(5) **Too Ill or Disabled**
(6) **Not Well-defined**

c. **Eligibility**

(1) **Priority Level One**
(2) **Priority Level Two**
(3) **Priority Level Three**
(4) **Priority Level Four**
(5) **Priority Level Five**
(6) **Priority Level Six**
(7) **Priority Level Seven**

d. **Age**

(1) **20 - 29**
(2) **30 - 39**
(3) **40 - 49**
(4) **50 - 59**
(5) **60 - 69**
(6) **70 - 79**
(7) **80 - 89**
(8) **90 - 99**